DOCUMENT RESUME

ED 399 121 RC 020 715

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TITLE A Resource Management Framework for Designing Rural Service Delivery Programs.
INSTITUTION Montana Univ. Affiliated Rural Inst., Missoula.
SPONS AGENCY National Inst. on Disability and Rehabilitation Research (ED/OSERS), Washington, DC.
PUB DATE 94
CONTRACT H133B20002-93
NOTE 36p.
PUB TYPE Guides - Non-Classroom Use (055) -- Information Analyses (070)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS *Community Resources; Community Services; Cultural Differences; *Delivery Systems; *Disabilities; Economic Factors; Models; Professional Services; Program Development; *Rural Areas; Rural Population; Social Services; *Vocational Rehabilitation
IDENTIFIERS Access to Services; *Resource Management; Rural Culture; Service Providers

ABSTRACT

As many as 15 million people living in rural areas report one or more long-term impairments that significantly affect their quality of life. In general, disabled people living in rural areas receive fewer services than do people in urban areas. For example, counties in Montana with the largest population centers received significantly more rehabilitation services than small population centers per adult reporting a work disability during 1988. This report examines rural service issues and describes an alternative model for providing rural rehabilitation services. Barriers to rehabilitation in rural areas include fewer professional resources, low incidence rates for specific disabilities, the multiplicity of rural provider's roles, economic factors, cultural diversity, and rural attitudes that may impede effective service delivery. In addition, the application of urban-based medical and multidisciplinary models to rehabilitation in rural areas has resulted in services that are both inefficient and dehumanizing. A major strength of rural communities is a strong sense of community and cooperation that encourages people to be more willing to become involved in the problems of others. A proposed framework for rural service delivery organizes key service elements of providers, recipients, and strategies, and allows for the combination of different service-delivery models to fit a particular rural area's needs and resources. The organization of services in existing models is analyzed, identifying additional methods for enhancing services and developing new models for rural service delivery. Achieving equity must be a central component in rural service planning that is sensitive to geographic considerations, rural/urban differences, and cultural differences. Contains 66 references. (LP)

ED 399 121

A Resource Management Framework for Designing Rural Service Delivery Programs

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The Montana University Affiliated Rural Institute on Disabilities is an interdisciplinary, university-sponsored organization that promotes the full participation in rural life by individuals of all ages with disabilities. The Rural Institute promotes this goal by developing and disseminating innovations in teaching, research, community services and policy advocacy.

Through a variety of technical assistance, training, research, information dissemination and service activities, institute staff work to:

- discover and develop state-of-the-art approaches to meet the challenges of living with a disability in rural areas;
- increase the number and quality of disability service professionals and providers in rural areas;
- provide information about rural areas to the public, professionals, and policy makers; and
- help people with disabilities in rural areas access quality social and educational services and health care.

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The Rural Institute on Disabilities receives core support from a grant from the U.S. Department of Health and Human Services, Administration on Developmental Disabilities. Individual projects are funded by varied federal, state and private sources.

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Acknowledgments

The authors wish to acknowledge the contributions of their many colleagues to the preparation of this paper. Rick Offner, developer and past Director of the Rural Institute on Disabilities at the University of Montana created the opportunities that brought both of us and the ideas we share together. We are also grateful to Randy Quevillion, PhD for his helpful comments on an earlier version of this manuscript, and for his discussion of rural strengths and weaknesses.

We gratefully acknowledge the **Lewistown News Argus** and the **Missoulian** newspapers for permission to reprint articles reflecting key points of rural life.

Dedication

We dedicate this work to the memory of **Steven R. Heyman,** whose ideas about rural community psychology strongly influenced our thinking and this monograph, and whose life was an inspiration to many of us.

This monograph was supported, in part, by a research grant (#H133B20002-93) from the National Institute of Disability and Rehabilitation Research, Department of Education. Opinions expressed here do not necessarily reflect the position or policy of the NIDRR, however.

Preface

The evolution of a field often reflects an ebb and flow between diversification and convergence. For example, the development of products and services in the private sector often involves market segmentation; the development or modification of products and services to meet the unique needs, desires, and values of people that differ from one another in significant ways, or to fit unique niches of a larger market.

The field of rehabilitation reflects a trend of diversification and segmentation. Much of rehabilitation can be viewed historically as a segmentation first of medicine and other generic fields (e.g., education, social work, etc.). For example, Vocational Rehabilitation emerged in the 1920's to address the work goals of a large "market segment" that was identified after World War I. More recently, independent living has emerged as a grass roots movement led by individuals with disabilities themselves. Interestingly, this latter divergence also offers a conceptual framework for convergence of rehabilitation by emphasizing a wholistic vision of independence.

This paper discusses the emergence of rural rehabilitation as a recognized and significant segment of the field. Several specific service models that have been developed to address the unique needs of people with disabilities living in rural areas are described. These are organized in a framework that suggest some general principles and strategies for designing rural service delivery programs.

While this paper focuses on rural service delivery, the emergence of rural rehabilitation also offers a potential framework for convergence. Two cornerstones of rural rehabilitation are the questions, What is the place of the individual in the community? and, How can the rural community be arranged so that all its citizens are acknowledged, respected, and involved? These values of rural community rehabilitation are consistent with the values of independent living for individuals with disabilities, but also with the values implicit in ecological branches of community psychology and community development. It is from these rural roots that models may emerge that point the way for other, larger communities.

About the Authors

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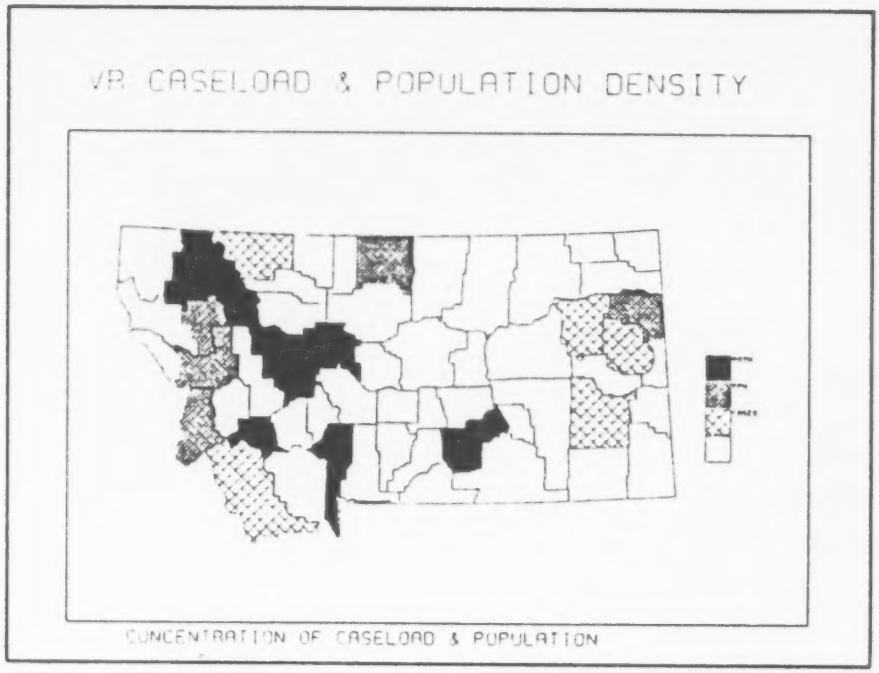
Introduction

As many as 15 millon people living in rural areas report one or more long-term impairments that significantly affect the quality of their lives (Seekins, Offner, & Jackson, 1993). This represents one quarter of the people in the United States with disabilities. As such, a focus on rural rehabilitation implies any type of rehabilitation, for individuals with any disability and of any age. Many difficulties exist in providing services to this great variety of people spread across 75% of our nation's landscape.

In general, people with disabilities living in rural areas receive disproportionately fewer services than do people in urban areas (e.g., Cordes, 1989). For example, when compared to urban areas, rural areas possess fewer rehabilitation hospital beds (Jackson, 1992). Even within states composed largely of rural areas, the allocation of resources appears to have an urban bias. Figure 1 displays the distribution of vocational rehabilitation services within Montana. In 1988, counties with the largest population centers received disproportionately more rehabilitation services per adult reporting a work disability in the census.

In response to these disparities, a number of writers have called for the development of programs specifically tailored to the unique and varied circumstances facing people with disabilities in rural areas (Offner, Seekins, & Clark, 1992). At their core, all of these viewpoints share a concern for equity. In rural rehabilitation, a concern for equity (Slesinger, 1991) focuses upon the way limited resources are distributed, both in the development of programs for rural and urban areas and in the development of programs among various rural areas. Unfortunately, current discussions are limited by the dominance of rehabilitation models that have emerged from urban areas. A framework for understanding rural service delivery is lacking (Solomon, 1986).

This paper examines rural service issues from several perspectives. First, barriers to rehabilitation in rural areas are reviewed. Following this is a discussion of the culture of rehabilitation, which is urban-based in its orientation. Third, some of the resources and strengths in rural areas are highlighted. These strengths are presented as unique assets available for use in rural rehabilitation service models. Finally, some alternative models for rural rehabilitation are reviewed. These models are analyzed using a proposed resource-management framework for the design of rural service-delivery programs. We conclude with some considerations we believe are critical to planning services for rural areas. Understanding the variety of choices is the first step toward expanding their use. Our goal here is to begin creating a vocabulary for understanding the choices.



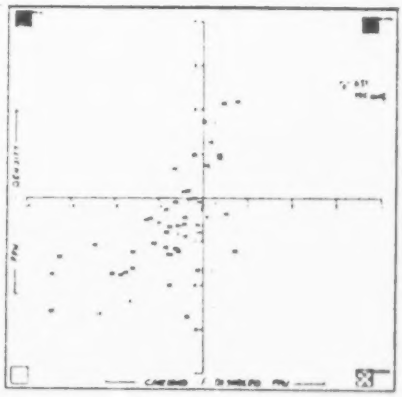


Figure 1:

The top panel portrays the distribution of services in proportion to the population of people eligible. The darker the shading, the greater the proportion of services.

The bottom panel graphs this same relationship. The intersection of axes represents perfect distributive equity. Counties in the upper right quadrant receive disproportionately more services. Those in the lower left receive disproportionately less.

Rural Barriers to Rehabilitation

The rural environment poses several unique challenges to establishing effective rehabilitation services. Many of these challenges are common to all areas of human service delivery. For this reason, discussions of rural-community psychology, rural mental health, and general rural health-care literature are relevant.

Fewer professional resources exist in rural areas than exist in urban areas (Murray & Keller, 1991). Professionals in rural areas must offer services for a wider variety of consumer problems, while functioning in greater professional isolation than do their urban counterparts. The distances providers must travel to contact consumers means that outreach work by providers will be time-consuming and expensive (Diamond & Van Dyke, 1985). These distances also mean that frequent visits to a centrally located service typically will be inconvenient and expensive for consumers.

Due to sparse populations, few people with the same disability or rehabilitation concern live in a given rural human-service catchment area. Because of these low base rates for specific disabilities in rural areas, an individual could be the only person with a particular impairment (e.g., spinal cord injury) in an entire county. This suggests a unique form of isolation.

Low base rates also require a rural provider to perform a multiplicity of roles while serving people with a wide variety of impairments and disabilities (Hargrove, 1982; Murray & Keller, 1991). This is in contrast to urban providers, who typically specialize in work with one, or a few, particular age groups or disabilities.

Economic concerns accompany these geographic and human resource considerations. The farm crisis, along with recent difficulties in timber and other resource-extraction industries, has accelerated recent trends of impoverishment in rural communities (Bullock, 1986; Fitchen, 1987, 1991; Rogers, 1988; Weeks & Drencacz, 1983). Given the current emphasis on capping or reducing human-service funding by all levels of government and the fiscal crises facing rural hospitals (Slesinger, 1991), this trend will, in all likelihood, mean even fewer dollars available for already financially strapped rural rehabilitation programs.

The social ecology of rural areas must also be considered. A tremendous range of human, as well as geographic, diversity exists across the rural United States (Flora et al., 1992). This diversity ranges from the ethnic European enclaves of many Midwestern farm communities, to the Latino communities of the Southwest, African-American groups in the Southeast, and to the more than 300 federally recognized American Indian tribal groups spread throughout the entire United States (Allen & Turner, 1990; Bureau of Indian Affairs, 1986).

This ethnic diversity is expressed socially in a variety of ways. For example, many rural white, Euro-American groups tend to value self-reliance and independence. Often, because of this orientation towards individualism and personal responsibility (Lowrey, 1980), they do not seek help. In contrast, American Indians traditionally are more oriented toward extended family and community values; as a

In a pique up the creek

McLaughlin Creek residents complain about authorities' handling of forest fire

By JOHN STROMNES
of the Missoulian

PARADISE – The welcome mat isn't out at McLaughlin Creek just east of Paradise.

Instead of mail boxes, there are "No Trespassing" signs nailed on trees and thick cables strung across roads that disappear into the underbrush.

The main road in the creek bottom is rocky, narrow, steep and not maintained regularly by anybody, which discourages all but local traffic. There are no road signs to let visitors know where they are now or how far they have to go to get someplace else.

Electricity is not available, unless you generate your own, which most folks do, using gas or propane-powered direct-current generators. Water is trucked in, or piped from mountain springs.

Because of longstanding grudges and past ill will, a visit from a local sheriff's deputy is viewed with distrust and suspicion, if not outright hostility. If a stranger ventures up the road, he's probably expected by somebody, and everybody soon knows about it because of a local CB radio network that local residents use.

In McLaughlin Creek, government services are not high on the list of values of local residents. Private property rights and privacy are.

"We like our woods, we like our remoteness. We don't mind being around the wild animals. I moved here to get away from the humdrum of the big city," said longtime resident Alice Barnes.

Residents are self-reliant. They don't need government to plow them out in winter. They do it themselves. And when it comes to fighting forest fires, they think they can do a better job than the government.

So it is no surprise that Barnes and others resisted when government agents showed up late at night on July 25 and ordered them to evacuate. Just because the deputies and search-and-rescue folks were trying in good faith to get them out of the way of a fast-moving and erratic forest fire doesn't seem to make much difference.

"It was a vindictive power trip. We called their bluff," said resident Bruce W. Hayes, one of the most vocal critics of the government effort to quell the Henry Peak fire in McLaughlin Creek that started last July 25.

KURT WILSON/Missoulian

A sign on the drive of a McLaughlin Creek residence reflects the owner's passion for privacy.

result, they often are not predisposed to seek help outside this network. Furthermore, when services are available to American Indians, they frequently present cultural dilemmas for both recipients and providers (Campbell, 1990).

At the same time, a number of core rural attitudes that can create obstacles to rehabilitation interventions are shared by many different rural ethnic groups. Euro-American rural groups often share with American Indians, and several other rural ethnic minority groups, a distrust of institutions, especially those institutions associated with state and federal government (Lowrey, 1980). This attitude also influences individuals to not seek services.

Many rural communities also exhibit resistance to change (Bachrach, 1977). This conservatism (Hoxworth, 1978) can become especially pronounced if a social-change effort is initiated by an outsider (Diamond & Van Dyke 1985). This suspicion of "outsiders" attempting to help (Buxton, 1986) may at times be the result of community experience. Assistance offered in the past may have been inappropriate, coming from urban-based professionals who lacked knowledge of the cultural differences or the physical realities of the rural area (Lowrey, 1980).

Along with this resistance to change, many rural communities exhibit what Flora et al. (1992) describe as "denial syndrome." They note that although problem denial exists in both urban and rural communities, certain elements of rural culture, particularly individualism and conservatism, cause it to be more dominant in rural areas. Denial can take the form of blaming the victim, or it can involve simply saying a problem does not exist: "People with physical disabilities are treated like anyone else in our community; there is no need for special services" or, more simply, "We don't have any people like that here."

The physical realities of rural life (Keller & Murray, 1982), especially weather, distance, and geographic isolation, can also contribute to a sense of powerlessness in the face of problems (Murray & Kupinsky, 1982). In short, due to these and other rural realities, many rural residents with disabilities do not believe they can control or improve their lives, and these beliefs influence the efficacy of rehabilitation interventions with rural residents.

The Culture of Rehabilitation

Broadly defined, rehabilitation is the process of a person's return to performing major life roles following a disabling event (C.V. Mosby Company, 1986; DeLisa, 1988). The goals of rehabilitation are to increase functional capacity and independence. To attain these goals, rehabilitation often focuses on the restoration of physical, psychological, and social capacities. Rehabilitation also may require changing factors in the physical and social environment (Mathews & Seekins, 1987; Pope & Tarlov, 1991). In rural areas, this at times may require changing the model of delivery for the rehabilitation services.

Lowrey (1980) has described a "culture of rehabilitation," developed primarily in urban areas. The provision of rehabilitation services is dominated by professionals, who, to a large extent, are attracted to the profession from urban areas. These professionals generally train in urban-based institutions, whose training faculty generally are also

from urban areas. As a result, the tendency of policy makers has been to apply various combinations of urban-based medical and multidisciplinary models to rehabilitation in diverse rural areas.

Unfortunately, these models do not always fit rural cultural, geographic, or professional resource realities. According to these models, rehabilitation generally follows a process beginning with assessment. Next, a treatment regime is developed by professionals from several different disciplines. Services are organized to capture the largest "markets" under assumptions of efficiencies of scale.[1] Consumers go to one or more centralized rehabilitation settings to receive services. Rehabilitation follows a linear, task-oriented approach, often involving somewhat impersonal interactions with a variety of specialist providers, each responsible for some component of the consumer's well-being.

Some of the implications of urban models can be seen through a case example. For an urban consumer to obtain services from her physical therapist, she most likely will need to arrange for paratransit to another part of town. This may require arranging for travel assistance and calling a central dispatcher days in advance to schedule a ride. On the day of the appointment, it would not be at all unusual for the consumer to wait for para-transit to arrive, wait while paratransit makes additional stops, arrive downtown to negotiate architectural access barriers, then wait again in the therapist's office because the paratransit schedule requires an early arrival. After this, the consumer must wait yet again for the paratransit system to collect her and return home. It is not unusual for consumers to spend half a day entangled in this process in order to receive an hour of rehabilitation services.

Yet, inefficient and dehumanizing as this process is, it represents unattainable luxury for many rural consumers. In rural areas, accessible public transportation is rare. To arrange transportation to services, a consumer may have to talk with several relatives, friends, or neighbors to see if any of them are planning a trip to "town" — or can be convinced to plan such a trip. This poses barriers to regular appointments and consistent services. Those who can make such a system work do so only through creativity and a high degree of motivation. For example, one of the authors knows of a Michigan woman who relies for transportation on a friend who drives a milk truck.

The character of the urban approach also can be foreign to many rural cultural groups (Clay, 1992). The process appears to be so alien to the values and world-view of many American Indians that they tend to boycott services (O'Connell, 1987). Those American Indians who do enter into typical rehabilitation services are often labeled as poorly motivated (Lowrey, 1980).

Variations upon urban rehabilitation models, as implemented in rural areas, raise questions of fairness

[1] Population base also may affect the application of treatment programs empirically validated in urban areas. For example, Allen, Walsh, and Seekins (in review) found that standard in-patient pain-management treatment did not generalize in one rural hospital. One explanation for the failure to replicate was that, in order to recruit enough patients to support the program, the rural hospital had to relax selection criteria. These selection criteria were easy to achieve in urban areas with large population bases. The presence of the professional capacity did not make up for a lack of patients with special characteristics.

and equity. In such circumstances, rural consumers may have to accept fewer services than their urban counterparts or do more to achieve the same rehabilitation outcome. For some, this may be a price worth paying in order to enjoy the benefits of rural life, or an example of a difference that is not necessarily worse. When rural consumers cannot even get access to services they need to live independently in their community, however, this becomes an issue of equity.

Due to these geographic, economic, and cultural factors, people with disabilities who receive little or no benefit from rehabilitation programs (Lowrey, 1980) are dotted across the rural landscape. Beyond an SSI or SSDI check, the assistance these people do receive is often primarily from family members, who may have limited means and knowledge of how to help.

A common solution to this dilemma has been to relocate rural people with disabilities from their home communities to an urban rehabilitation setting. However, relocation disrupts support systems important to the rehabilitation process (Rojewski, 1992). Moreover, it initiates a major life transition during the personal crisis that often accompanies the onset of disability. Therefore, while relocation may increase the array of rehabilitation services available, it also is likely to increase the potential for adjustment problems associated with both the disability and dislocation.

This litany of rural ills and the barriers they impose upon human-service efforts has been widely discussed elsewhere (cf. Bachrach, 1983, Buxton, 1973; Eisdorfer, Altrocci & Young, 1968; Fitchen, 1992; Flax, Ivens, Wagenfeld & Weiss, 1978; Flora et al., 1992; Fraser, 1987; Gertz, Meider, & Pluckhan, 1975; Hargrove, 1982; Heyman, 1983; Huessy, 1972; Jeffrey & Reeve, 1978; Jones, Wagenfeld, & Robin, 1976; Murray & Keller, 1991; Soloman, 1986). However, this focus upon rural barriers may stem, in part, from professionals' preoccupation with urban models. It also reinforces the rural services status quo and discourages efforts to improve services. As a result, we often fail to appreciate rural strengths. These strengths must be incorporated into rehabilitation planning. Unfortunately, they often are not recognized or used because they do not fit the urban model (Lowrey, 1980). This is especially problematic given several unique opportunities that rural environments afford for innovative service planning.

Rural Strengths

A major strength of rural communities is that rural inhabitants are likely to know their neighbors (Mazer, 1982). The sense of community and cooperation frequently is stronger than in an urban setting. In Eastern, Southern, and Midwestern farm communities, neighbors' relationships may go back several generations. On Indian reservations, these relationships often are based upon extended family and kinship structures. The fewer numbers of inhabitants in rural areas also means less opportunity for diffusion of responsibility (Darley & Latane, 1968). For these and other reasons, people generally are more willing to become involved in the problems of others. Often, closely knit social-support networks are in place before a rural person experiences a personal crisis (Mazer, 1982) such as the onset of disability. It has been suggested that the smaller, denser nature of these social networks in rural communities has a buffer effect on depression (Quevillion & Trenerry,

1983). The scarcity of human service professionals in rural areas further promotes the likelihood of neighbors helping each other.

Because the scale of things in rural areas is smaller, community problems are less overwhelming. Communication among agencies is generally easier, and typically on a first-name basis. Personalities and individual decisions dominate, rather than a faceless bureaucracy. This also generalizes to a professional's relationships with consumers. Often, a rehabilitation worker will personally know many potential consumers in a county. This often permits greater responsiveness to individual needs and a greater willingness to be flexible.

Typically, fewer institutional obstacles to a provider's efforts exist in rural communities. Many rural professionals describe the personal fulfillment of working in an environment in which one person can make a tangible impact; one individual often can make a difference. The rural provider's high level of community visibility, in comparison to the relative anonymity afforded urban providers, is often cited as a disadvantage of work in rural settings (Buxton, 1973)[2]. However, Heyman (1982) notes that, from the perspective of program development and implementation, this can be an advantage because rural institutions tend to function through organizational strategies focused on personal contact and the community evaluation of this contact.

Rural areas also have potential advantages for the consumer movement. Although a person with a disability may be isolated from peers by long distances, rural visibility also means that this person is likely to know others with a disability in the community and be known by many in the wider community. This facilitates networking within pre-existing formal and informal community structures. It also is possible that rural people with disabilities will know many service providers and their supervisors on a first-name basis. From a consumer perspective, the organizational scale is more human; the task of providing advocacy to individualize services to needs seems less daunting. On the community level, pre-existing personal relationships between people with disabilities and community leaders often can facilitate the process of community adaptation to and acceptance of disability (Bogdan, 1991). Perhaps more importantly, these same structures form informal social support networks that include "natural helpers" (Heyman, 1986). People turn to these helpers in times of distress; they are an important resource for rehabilitation planners.

The rural environment and lifestyle also can enhance the quality of life for a person with a disability. Many people who choose to remain in rural areas do so for quality-of-life reasons. For a variety of lifestyle considerations, such as safety, pace of life, and sense of community, they find rural areas appealing. This probably explains survey results that find rural inhabitants happier with their locale, and more interested in staying in it than are their urban counterparts (Rogers, 1988). Often, such considerations are key to a person's adaptation to disability.

Finally, rural areas provide recreational opportunities long recognized by mental health professionals as therapeutic (Heyman, 1982). Outdoor recreation opportunities and wilderness-skills training used by mental health programs could be adapted to enhance the life skills and self-esteem of both rural and urban rehabilitation consumers.

[2] Familiarity can also present problems of confidentiality.

Rural Community News from...

Elizabeth Davis 374-2274

Moore

Our own Francis Waite attended the School Food Service Conference, July 31-Aug. 4. It was sponsored by the School Food Division of O.P.I. and the Montana School Food Association in Billings.

As a member of the executive board in the capacity of membership chair for the state association, Francie was kept very busy at her booth.

As always the pre-conference certification classes were excellent as well as the regular break-away sessions. Lots of good information was shared.

Aug. 4, Francie was met in Billings by her sister and niece from Idaho Falls, Idaho, and her daughter, Rene, for a car trip to south central Nebraska.

There they joined other family members to celebrate their mother's 65th birthday. They also helped their folks with a farm auction since they were retiring from farming.

Mr. and Mrs. Jim Naylor and Johanna Bricker from Lewistown, were recent visitors at Max Tyler's Sunday.

Rev. Angela Gapay was supper guest at Chuck and Mary Brickers. They went to the garden and picked cucumbers until dark.

A group of friends gathered at Hobson Lounge Friday evening in honor of Virginia Melichar's birthday.

Kyle Carr was a visitor at the home of his great-grandmother, Elise Johnson.

Daughter, Phyllis Taylor, and sister, Helen Hickey Barber of Big Timber, held a surprise birthday party for June Nessan. There were 18 friends to help enjoy a delicious luncheon. The evening was spent visiting, playing the piano, and singing.

Greg Greenwood was home to do some bow hunting with his dad. Greg works as maintenance person at Tiber Dam for the Bureau of Reclamation.

Mary Hudson of Boise, Idaho, was guest at her mother, Lucille Hudson's, for several days. Mary then took her mother to Sheridan, Wyo., where they visited her son, Bob, and his wife for a week. Mary returned to Boise to begin another year of teaching in the Meridian school.

The Catholic church's of Moore and Hobson have a new Mass schedule. It is as follows:

First and third Saturdays in Moore at 8:30 a.m.

Second and fourth Sundays in Hobson at 8:30 a.m.

Tuesday Sept. 13, there will be a liturgy meeting at 7 p.m. at the home of Cherilee Martin.

Saturday Sept. 17, at 8:30 a.m., Mass will be held in Moore. Coffee and rolls will be served.

Friday Sept. 23, from 10 a.m. to 2 p.m. a rummage sale will be held in the Catholic church basement in Moore, with a sack sale at 1:30. Coffee and desserts will also be for sale.

Wednesday Sept. 21, at 12:30 p.m. the Moore Woman's Club friendship luncheon will be held at the Clubhouse. All members are to bring a salad and a friend.

Ron Martin of Billings spent his spare time from harvesting at the Max and Dorothy Mason home. Ron's sister, Leola and Glen Tusler of Helena, and Ron's cousin, Paula from Oregon, were also guests of the Mason's.

Jack and Lauretta Mason of Walla Walla, Wash., visited his mother, Midge and Jerry Dull, and brothers, Glen and Max Mason families.

The group enjoyed a picnic at Crystal Lake, a supper at Dulls, a trip up South Fork, and the Yogo over at Stanford where they enjoyed a supper and visiting.

Midge and Jerry Dull hosted a dinner at Yogo Inn for Jack and Lauretta, Glen, Rus, Dan, Max and Dorothy Mason, and Sue and Shame Balthazor.

Bob and Dina Saldevar from Alto, N.M., visited her cousin, Max Mason and family. Dina's maiden name is Long, and she lived in Moore many years ago.

Mildred and Lloyd Neudick, Lorraine Berg and Dorothy Mason attended the Valle Vista picnic for all residents. They enjoyed being with relatives, Jenny Wichman and Tony Barta.

Frieda Lowery motored to Harlowton with Mr. and Mrs. Elton Strunk of Lewistown, to attend a joint birthday party for Mr. Strunk, Mr. Morley and Frieda Lowery, at the home of Mary Carrier.

A delicious potluck was enjoyed by 12 friends with an afternoon of reminiscing.

Bud and Betty Marshall of Billings, were visitors of his sister, Sharon and Gary Greenwood. The Marshalls were attending the Wally Bynum Caravan Rally, held at the Lewistown fairgrounds over Labor Day weekend.

Wilmer and Thelma Hertel were among the group who rode the Charley Russell Chew-Choo train to Geraldine. They reported it as a wonderful trip with unusual scenery where they crossed three big trestles and enjoyed the camaraderie.

Over Labor Day weekend, all eight children and their families of Ray and Gertrude Barta were home to celebrate the folks 40th wedding anniversary.

Saturday night, mom held a cookout in the yard. Tom and Bev Nicholson from Buffalo joined the group.

Sunday they families went to the Hackamore for dinner, then an open house was held in the afternoon where many friends joined the celebration.

Karl and Marian Hertel held an open house party Sunday evening with nearly a hundred relatives and friends attending. A bountiful potluck meal and visiting was enjoyed by all.

Moore School got off to a great start Aug. 23. We share a new superintendent, Mr. John Baule, with Hobson. He spends a half-day at each school.

We have a new music teacher, Mr. Scott Molner. He and his wife, Elaine, live up Rock Creek.

We have six kindergartners: Jessica Morris, Stade Clark, Anthony Barthol, Tyler Gilkey, David Schleppy and Michael Smith.

New first graders are: Michael Bricks, Arin Frehse, Cory Mitchell, and Lucas Zumstag.

A new second grader is Jacob Zumstag. A new third grader is Ashley Irion. A fifth grader is Jeannie Wood. Eighth graders are, Tammy Rea and Jeff Brady.

Ninth graders are Kriston Johnston and Stephanie Thomas, 10th graders are Richard Huston and Eric Bush, and a new senior, Michael Buchanan.

The Moore High School Chapter of the National Honor Society is recycling aluminum cans as their annual fund-raiser. Anyone may contribute by bringing aluminum cans to the school or contacting a National Honor Society member.

Several Moore graduates have left for college. Those I have heard about are Tammie Wichman, Eric and Ted Nelson, Gary Heilig, Toby Hertel, Mark, Christy and Tara Taylor, Connie Jenkins, Holly Greenwood, David Jenkins, Rene and Justin Waite and Stephen Hodgeson.

The Moore Methodist Church enjoyed having Rev. Heath from Lewistown carry on in the absences of Rev. Angela Dapay.

Issy Janicek accompanied her son, Jim and Barbara Janicek, on a trip to Helena where they helped their son, Bobby and Diane, build their garage in south Helena.

Issy reported that she enjoyed the ride, visiting and beautiful mountains.

Janis and Jim Webber, Issy's cousin, came for a visit while there. Bobby Janicek works in the workman's compensation office in Helena.

Alternative Models for Rural Rehabilitation

Given the great cultural and geographic diversity of the rural United States, different rehabilitation service strategies need to evolve for different communities. Any alternative to the urban rehabilitation model must recognize and adapt to this diversity yet remain generally appropriate for rural areas. Such a model would serve as a basis for developing variant rural service-delivery strategies.

A Rural Service Delivery Framework

There is no easily described method for combining resources to meet human needs — especially in rural areas. Generally, planners and developers consider relevant factors, then look for models and procedures developed elsewhere. If there are no models that can be adapted for one's specific purpose or area, then one must develop them.

We propose a method for combining and applying different models of service delivery to diverse rural areas. Our purpose is to organize some of the existing models of rehabilitation into a resource-management framework suitable for rural service-delivery planning. The goal is not to prescribe a specific model for all rural locales. Rather, this framework is intended as a conceptual tool to help generate individualized, situation-specific models for rehabilitation services.

A service-delivery framework is an outline of how to organize resources. Figure 2 provides a framework for considering potential rehabilitation service-delivery models for a specific purpose in a specific rural area. The framework organizes the key service elements of providers, recipients, and strategies into a cube. The intersection of the various elements along each dimension describes a possible service-delivery model. The framework allows for the combination of different service-delivery models to fit a particular rural area's needs and resources.

A central question in organizing activity to achieve independence and community integration of people with disabilities involves the concepts of service and support. The two are treated synonymously by the proposed framework, the premise being that their functions are essentially the same. In addition, according to the framework, recipients and providers of services can exchange roles at various times. For example, we typically think of a person with multiple sclerosis as the rehabilitation consumer and of a physical therapist who works with this person as the provider. However, if an individual with multiple sclerosis teaches a workshop for physical therapists on barriers to access in rural areas, the physical therapist becomes the consumer and the roles are reversed.

Recipients and Providers of Services

In this framework, providers and recipients are organized into seven general groups. These groups include consumers, families, volunteers, professionals, paraprofessionals, agencies and community institutions. For local planning, the framework can be expanded to include specific recipients and providers.

Consumers

Clearly, people with disabilities are the primary

consumers of rehabilitation services. However, consumers do not live and work in isolation. Like all rural residents, they are participants in broader networks (Heyman, 1986), functioning both as recipients, and providers of services and supports in widely varied communities of location, interest, and affiliation.

Family

While direct service, such as physical therapy, can have a dramatic impact on an individual's ability to live independently, the amount and type of social support a person finds in his or her family and other social networks may be even more important (Price, 1981). Members of these networks need to also be defined as appropriate recipients of services. Appropriate services can facilitate these different networks ability to support the efforts of individuals with disabilities to live independently in the community. The American Association of University Affiliated Programs (1990) defines these types of services as indirect services.

Professionals

Traditionally, service providers are defined as licensed rehabilitation professionals who provide direct services to a person with a disability. Because of human-resource limitations in rural areas, the availability of a range of professional providers is uneven and other models, such as the triadic model, have emerged.

Paraprofessionals

The triadic model was an early model that emerged in the field of developmental disabilities (Tharp & Wetzel, 1969). In this model, a licensed professional (in this case, a psychologist) trained paraprofessionals either to provide direct services or to serve as a trainer of other paraprofessionals, who provided the services. More recently, triadic models have been extended to family members and volunteers, further broadening the service reach of the professional at the top of the triad.

Agencies

Individual professionals and paraprofessionals often are organized into service-delivery agencies. When designing services, it is important to consider these agencies as part of the network of providers. Their rules of operation govern both the behavior of many individual providers and the allocation of resources for services. Further, service changes impacting individuals often occur at the level of system, where rules are changed for whole networks of agencies. Finally, any effort to modify direct services for even one individual often requires either permission or change at agency level.

Community Organizations

In discussion of rehabilitation services, attention typically is paid to *provider systems*; to rehabilitation, special education, and treatment *programs*; and to *professional specialists*. Yet, in rural areas, the largest source of care and assistance provided to people with disabilities comes from what might be termed "natural structures" of community support (Price, 1981; RTC: Rural, 1992). These natural structures include rural community institutions and personal networks outside the specialized professional-service network.

The development of the Americans with Disabilities Act (PL 101-336) was based, in part, on notions of integrated, as opposed to segregated,

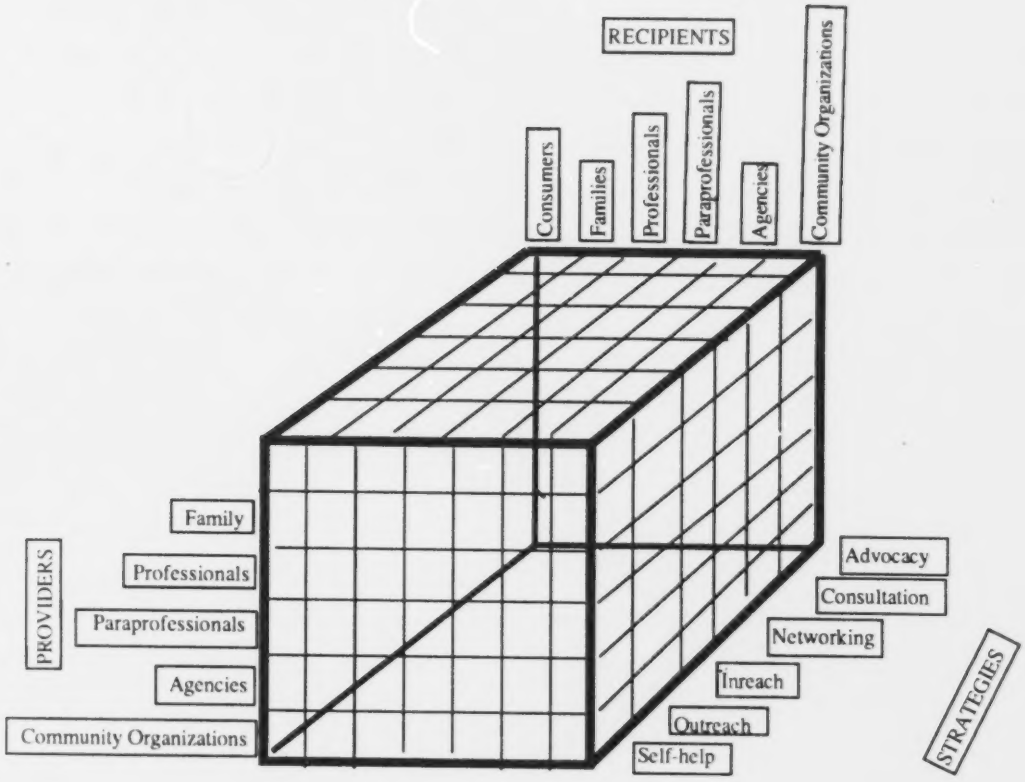


Figure 2: Framework for combining services to build a rural rehabilitation service delivery program.

service models. While specialized service systems (e.g., medical rehabilitation) may be critical for many people at different stages of life, the underlying philosophy of the ADA is that these special services should no longer dominate policy and planning discussions. Instead, the ADA views specialized service as only one of several ways in which individuals with disabilities meet their needs and achieve their goals. One implication of the ADA philosophy is a requirement that planners and providers challenge, where appropriate, concepts that continue to call for expanded funding of "separate but

equal" services. Instead, planners must consider, whenever possible, how service providers to the nondisabled population can also provide services to people with disabilities. This perspective may be useful in expanding the range of potential providers of rural services to include generic service providers such as libraries, churches, pharmacies, public health offices, county extension offices, hardware stores, gas stations, and post offices, as well as volunteer organizations and more informal community social structures.

Strategies

Within the proposed framework, six types of service strategies are described along one dimension. These strategies include self-help, inreach, outreach, coordination, consultation, and advocacy. Approaches typical of each strategy are described below.

Self-help

Since the mid-1960s, self-help has emerged as an addition and alternative to the professionalization of rehabilitation services and support (Schure, Slotnick, & Jeger, 1982; Gartner & Reisman, 1977; Reisman, 1965). Ideological frameworks differ regarding the nature of the helper role and its appropriate relationship to professionals and agencies; however, all share a view of the person with disability, or the "consumer," as someone possessing unique knowledge, experience, and motivation. Given opportunity and proper direction, self-help models encourage consumers to use their unique abilities to benefit themselves and others similarly situated. As a starting place, this involves the individual with a disability controlling his or her own life by taking responsibility for managing his or her health and independence. Usually self-help strategies also involve direct help to other consumers. These cooperative efforts provide direct services through peer counseling, emotional support, and mutual assistance in a variety of life tasks. More recently, consumers have become involved as consultants to agencies and as systems-change advocates (Fenton, Batavia, & Roody, 1993).

The self-help movement has contributed significantly to the emergence of an independent-living paradigm for people with physical disabilities (DeJong, 1983; Crewe & Zola, 1983). The paradigm defines consumers of services — people with disabilities — as the people in control of services. It also views people with disabilities as being in the best position to direct agencies that provide services and support. While self-help strategies seek to empower the consumer, build on traditions of independence within rural values, and are consonant with current disability philosophy, these efforts can benefit from professional support.

Inreach

Inreach requires the consumer to travel from the rural community to receive services. Services typically offered through inreach are direct services. Examples of inreach strategies include inpatient medical rehabilitation centers, professional offices, and university-based clinics. At times, inreach can require a rural consumer to temporarily, or even permanently, relocate to an urban area.

The advantages of inreach include centralization of specialized service delivery. This allows the delivery of specialized services to a large number of patients at a lower cost to the provider. Disadvantages of this strategy fall mostly upon the rural consumer, who

bears the cost and inconvenience of traveling long distances or of relocating to an urban area. Often, the distance between a consumer's rural community and the urban center means key components of an entire rehabilitation program are unavailable. Distance also poses significant obstacles to the involvement of local rural service providers in the planning and execution of treatment (Seekins, Jackson, & Offner, 1992). This can lead to difficulties in the provision of follow-up treatment upon return to the rural community (Allen et al., in review).

Outreach

Outreach may be the most commonly used rural alternative to inreach. Outreach involves rehabilitation professionals providing direct services in locations more accessible to rural consumers, often in the communities in which they live or in their homes. Outreach services can be provided through direct service delivery, satellite offices, or traveling clinics.

In direct-service outreach, individual specialists travel to consumers' homes or use a local provider's office. Case management is an approach using this strategy. Case managers regularly visit consumers at home and might provide a variety of services, including assistance in daily-living functions, monitoring treatment progress, providing transportation to more specialized providers, and advocacy. The primary advantage of this strategy is that services are accessible to all consumers. However, for more specialized rehabilitation services, this approach is often prohibitively expensive in rural areas.

Satellite offices are professional office spaces in rural communities used by itinerant specialists on a regularly scheduled basis. This approach to delivering specialist services is less expensive than direct-service outreach. However, many rural communities do not have rehabilitation caseloads large enough to support satellite offices. If this is the case, as with inreach, a rural consumer may still have to travel significant distances in order to receive services at a regional satellite office.

The traveling clinic is an outreach approach that combines some of the benefits of both direct delivery and satellite offices. Traveling clinics are teams of itinerant specialists who travel to local communities and use existing professional facilities. Traveling clinic-team composition is fluid. Specialists are assigned in response to outlying communities needs. The use of existing community facilities further reduces overhead costs. Many rural communities or small networks of rural communities can support traveling rehabilitation clinics.

Networking

When addressing needs, professionals and advocates often think in terms of developing new services. Yet, many of the services people with disabilities may find useful already exist in one form or another in the community. Rather than develop a new service, many advocates work to include people with disabilities into the existing formal and informal networks of their community. This approach to rural rehabilitation often seeks out an existing service in a rural community, adapts it to a new need, then coordinates it with other services to expand resources available to meet consumers' needs (Jackson, Seekins, & Offner, 1992). For example, rather than develop a new health-promotion program, disability advocates have been successful in convincing community programs such as the county library or extension

service to accept people with disabilities into their existing programs. In a variation to this approach, providers link up with more informal community social networks in pursuit of a rehabilitation goal. For example, disability advocates may help church groups provide counseling or support services to people with disabilities.

Consultation

This method of service delivery uses rehabilitation specialists to train rural generalists in specific skills individualized to the needs of a particular rural consumer. Training/consultation models typically make use of staff training, consultation networks, and communications networks in the delivery of services.

In staff training, rehabilitation specialists provide rural generalists with workshops, educational materials, on-the-job training, and direct supervision. This training allows the generalist to learn specific tasks typically performed by a specialist. This allows access to services otherwise available only at distant, urban-based comprehensive-rehabilitation centers that are not readily accessible to the rural consumer.

As the generalist-trainee masters specific skills needed by a particular consumer, the need for training and supervision become less frequent. However, continued consultation is essential for generalists fulfilling this role. This can be provided by consultation networks that provide access to specialists available on a regular basis.

Recent advances in telecommunications, computer networking, and interactive television have improved the ability of consultants to use distance education for consultation. Advances in these new technologies hold great potential for this rural strategy.

Advocacy

Advocacy is not generally viewed as a service. However, advocacy often focuses on changing the quality, amount or accessibility of services (Balcazar, Seekins, Fawcett, & Hopkins, 1988). Though advocacy groups are absent in many rural areas (Seekins, Jackson, & Dingman, 1991), they have great potential. Because the institutional scale of rural government is small, a group of committed citizens can have a relatively large impact. In addition, many of the barriers to grassroots organizing erected by rural distances have been lessened by the advances in communications networks discussed above.

Similarly, existing community organizations often wield considerable power. These organizations can range from churches to the local rural volunteer fire department to the Grange. When problems arise in a person's rehabilitation program, these organizations often can get things done. Because of this, these organizations can become indispensable through their ability to perform a variety of needed services, ranging from advocacy work to forming transportation networks.

Using the Rural Resource Management Framework

The framework we propose can assist in understanding the organization of existing models of services, identifying additional methods for enhancing services and developing new models for rural service delivery. Figure 3 shows the framework in the

analysis of several innovative rural programs.

The CARES Project

The Coordinated Ambulatory Rehabilitation Evaluation Services (CARES) Project (Page, Bornhoeft, Barcome, & Knowlton, 1985) was developed to organize limited resources, provide training, and arrange assistance for rural North Dakotans with disabilities. The project offers multidisciplinary rehabilitation resources to underserved rural areas in a cost-effective manner. In this program, specialists from a rehabilitation center employ consultation strategies to provide outreach training and technical assistance to generalist practitioners in rural communities.

The CARES model uses a three-stage process to achieve its goal of establishing ongoing, locally based rehabilitation programs of individualized services for rural residents. Phase I uses a core team of rehabilitation specialists from a comprehensive rehabilitation center that travels bimonthly by chartered aircraft to the host acute-care hospital. The team provides evaluation, reports its findings and recommendations, and participates in patient staffings. The team also conducts inservice workshops and other training with the host hospital staff.

Phase II initiates a transition to greater local-provider involvement. Local providers are paired professionally with the core team members. For example, a local school speech pathologist, as the only language resource in the area, is trained by a communication specialist in specific skills needed for working with area adults with speech impairments. Telephone consultation supplements bimonthly staffings in Phase II.

Finally, Phase III completes the transition to local care. Local resources, such as social workers, usually exist for some of the team roles. These providers can be incorporated early in the process. However, other specialists, such as clinical psychologists and physiatrists, generally must be provided through continuing arrangements with the comprehensive rehabilitation center.

Vocational Rehabilitation for Traumatic Brain Injury

Another example of an alternative rural model is an approach described by Prickel and McLean (1989) for the vocational rehabilitation of people with head injuries. This model uses networking strategies. An experienced rehabilitation professional is brought into the rural area to serve as coordinator. The coordinator mobilizes resources and existing professionals in the community to work as a team. This model also has three stages. First, the coordinator is selected. Next, this coordinator enlists other key members to form the rehabilitation team. In head-injury rehabilitation, this includes the consumer, family members, a psychologist, a physician, a vocational counselor, an insurer, and other interdisciplinary members as needed. In the third stage, the coordinator who provides for education and training as needed, sets goals, organizes services, coordinates team actions and provides team support. This is facilitated by regular team meetings, which also focus on team burnout and stress. This approach allows for flexibility in meeting the demands of different rural locales. It efficiently uses the skills of existing professionals in a community and also initiates proactive measures to combat burnout.

The Range Exchange

A third model, employed by the Range Exchange, uses an existing community institution in rural Montana that originally served only people without disabilities. In the Range Exchange, U.S. Department of Agriculture County Extension Service Homemaker Volunteers provide a variety of outreach services to assist rural people with disabilities in daily-living activities (Proctor, Wells, & Seekins, 1992). Most rural counties have Extension Service agents and Homemaker Volunteer Units. The function of the County Extension worker is to provide information on a wide variety of rural issues -- from crops and livestock to home repair. As sources of information important to rural life, they can provide information relevant to the unique needs of rural people with disabilities. Homemaker volunteers also function as sources of information about community services, providing a fixed point of referral for these services. In addition, some prove to be in an excellent position to provide some degree of coordination among existing services. All too often, despite their considerable human-service potential (Coward, VanHorn, & Jackson, 1986), Extension workers' knowledge of local geographic and cultural considerations goes untapped by rehabilitation planners and professionals.

IMPACT

The IMPACT program uses outreach strategies to provide psychiatric rehabilitation services to people with severe and persistent mental illness in rural South Dakota. The program provides a variety of case management and psychosocial rehabilitation services, typically in the person's home and the person's rural community. An innovation of this program has been the integration of several existing community institutions (networking), such as the local police department, in treatment strategies. For example, IMPACT program participants all carry ID cards to show to police if they are stopped by an officer or experience problems in the community. Police then contact and consult with IMPACT on appropriate measures for this individual. This example nicely illustrates a rural strength as this level of personalized integration of institutions and services is typically not possible in urban communities.

Transportation Cooperatives

A fifth example, described by Kidder (1989) and Fitchen (1992), involves several different rural service agencies cooperatively pooling transportation services to develop regional transportation networks for residents with disabilities. For example, a local traveling rehabilitation clinic, a case-management program for persons with severe and persistent mental illness, a senior citizens center, and a group home for people with developmental disabilities all could pool resources to fund a single van and driver to transport consumers to local services.

Do-It-Yourself Assistive Technology

Finally, we wish to focus upon self-help. Here consumers assist other consumers by providing a direct service through their own outreach efforts. For example, there is much discussion about the remarkable assistive technology now available and the difficulties in funding its purchase. However, providers often ignore the contributions of consumers who modify, repair, and even create their own equipment (Dixon & Enders, 1983).The flexibility of these groups, along with their emphasis on informal social contacts, is in keeping with traditional rural

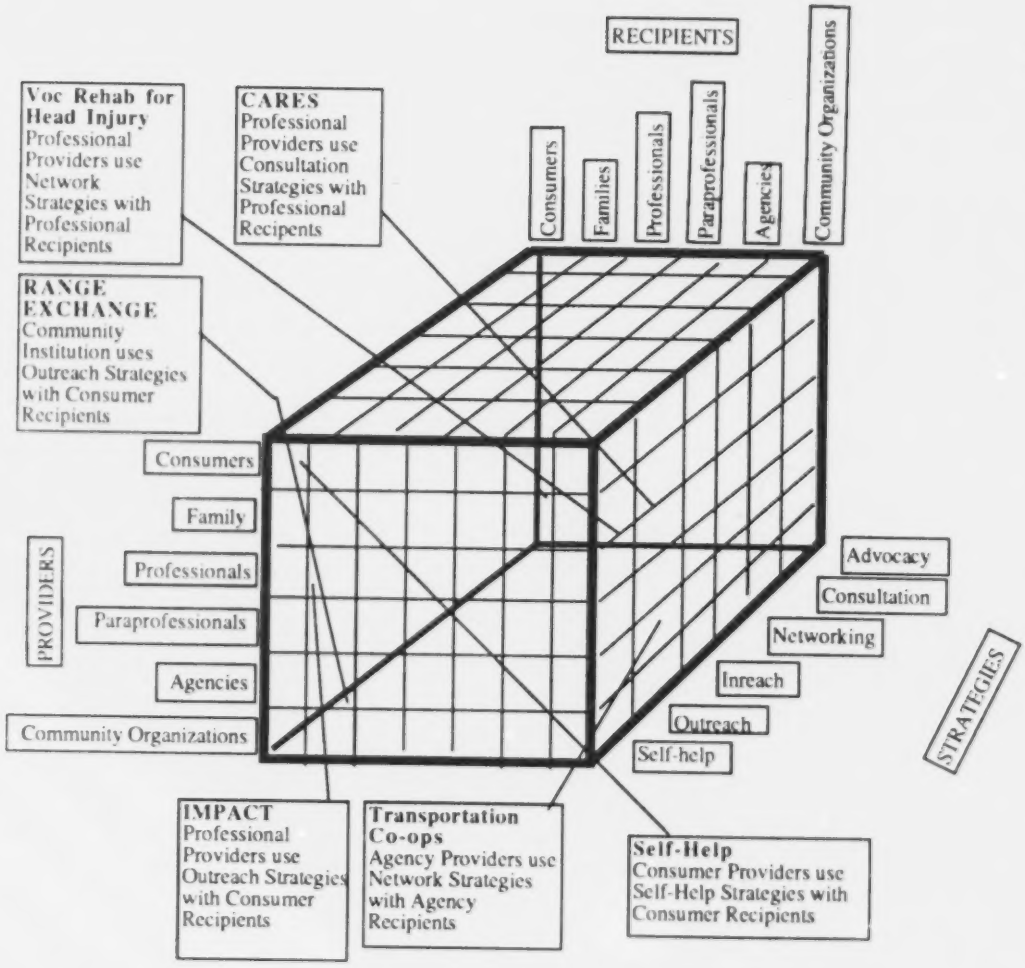


Figure 3: Several rural programs are highlighted as examples within the framework.

social preferences (Fitchen, 1992). Our experience includes many examples of this in rural areas, where independence and self-reliance are typically the norm.

Rehabilitation programs are multifaceted. For purposes of example, we have highlighted only a central component of each of the above programs. For example, the use of local police by the IMPACT program indicates that existing community institutions also have been incorporated into this rural program. As the reader has probably noted, each of the above examples typically uses more than one strategy. Multiple providers, recipients, and strategies are the norm in effective rural programming. The framework can be helpful in analyzing these components and in suggesting new variants and additions.

Some Important Considerations in the Use of the Framework

Instead of a single model to fit all rural areas, we propose here a framework for designing different rehabilitation-service models for different rural areas. Rural service-delivery methods must vary widely across different settings. We have outlined some of the vast cultural and geographic differences among rural areas that necessitate this flexibility. These factors, along with important differences in attitudes and in the accessibility of services between rural and urban areas, require planners to think in terms of a variety of alternatives to urban-based models of rehabilitation. Providers aware of these differences can creatively incorporate many of the often overlooked rural strengths into situation-specific service-delivery options to meet the unique needs of a particular rural area. Different areas will require different models. Clearly, flexibility in approach is key. However, three final considerations must guide implementation of this framework.

First, our intent is not to suggest that individuals with disabilities, or their family members, should bear most of the responsibility of rehabilitation service provision. Similarly, rural communities should not be on their own. Unfortunately, this is all too often the case for many rural families of people with disabilities, who are left on their own to provide for a family member with a disability as best they can, with little guidance or support (Fitchen, 1992). Self-help, family assistance, and community structures of natural support must be acknowledged and supported, particularly in rural areas. However, care must be taken to see they are not exploited. A further lesson from many of our current efforts in service delivery to rural areas is that services and supports for people with disabilities often do not need to be segregated or "special," but can instead be integrated into the natural flow of community life.

Second, in all considerations of program planning, consumer involvement is essential (Fenton et al., 1993; Jackson et al., 1992). This is especially true for rural areas, where consumer input can assure that service design will be culturally and geographically appropriate for that specific region and situation.

Finally, rural areas often suffer from shortages of specialist providers (Murray & Keller, 1991). In some respects, this will always be a problem in comparison to urban areas. This is especially problematic given

that there are data indicating that the incidence of disability is proportionally higher in rural than urban areas (Seekins, Jackson, & Offner, 1993). Nonetheless, despite this greater proportion of disability in rural areas, the base rates for a particular type of disability in any given rural area will be low. In areas of low population density, provider specialization is less possible (Hargrove, 1982). However, many of the basic services provided by specialized professionals and paraprofessionals are similar across a wide variety of disabilities. For example, much of the assistance provided by case managers is similar across a range of disabilities, including spinal cord injury, head injury, and severe and persistent mental illness. Communities that cannot afford specialized case-management services for several different disability groups could instead pool resources and offer a unified case-management program. This would require flexibility and creativity in the allocation of funding among various local agencies. A compelling case can be made for coordinating many of the services for physical, developmental, and psychiatric disabilities in rural areas in order to provide more comprehensive and equitable services for all rural people with disabilities (Pope & Tarlov, 1991).

In Pursuit of Equity

A concern for equity must be a central component of any rural rehabilitation planning. Equity does not mean rural services should be identical to urban services. More importantly, equity requires attention both to rural diversity and to the allocation of services between rural and urban areas, among different rural areas, and among groups of people living within the same rural area. For example, 46 percent of American Indians live in rural areas (O'Connell, 1987). Although this group of rural Americans is at greatest risk for disability (O'Connell, 1987; U.S. Census, 1983), it receives the fewest services of any rural group (Clay, 1992). These rural residents, along with all rural residents, need equal access to culturally appropriate services.

A concern for equity requires rural service planning that is sensitive to geographic considerations, to rural/urban differences, and to cultural differences within rural areas. The active input of rural consumers is one of the best ways to facilitate this sensitivity. As important, program planners must become more flexible about reducing barriers created by rules of eligibility for specific services or programs, in the degree to which they develop specialized programs, in the age ranges to be served by any particular program, in the locations at which services can be provided, in the selection of service providers, and in the manner of service delivery. Planners also must become more sensitive and accommodating to the goals and desired outcomes of people with disabilities living in rural areas.

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